| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *BCBS-126629620* | *State:* | *Rhode Island* |
| *Filing Company:* | *Blue Cross & Blue Shield of Rhode Island* | *State Tracking Number:* | |
| *Company Tracking Number:* | *GM-201005* | | |
| *TOI:* | *H15G Group Health - Hospital/Surgical/Medical Expense* | *Sub-TOI:* | *H15G.001 Any Size Group* |
| *Product Name:* | *Group Commercial Medical* | | |
| *Project Name/Number:* | *Group Commercial Rating Factors for 2011/GM-201005* | | |

# Rate/Rule Schedule

| Schedule Item Status: | Document Name: | Affected Form Numbers: (Separated with commas) | Rate Action:* | Rate Action Information: | Attachments |
|---|---|---|---|---|---|
| | Group Rate Factor Filing | HMC2C SA (01/08) and amendments GRPAMEND (01/09) and GRPAMEND (01/10), Classic SA (01/08) and amendments GRPAMEND (01/09) and GRPAMEND (01/10), BlueCHiP SA (01/08) and amendments GRPAMEND (01/09) and GRPAMEND (01/10), HM HDHP SA (01/08) and amendments GRPAMEND (01/09) and GRPAMEND (01/10), SO PPO SA (01/08) and | New | | BCBSRI Group Rate Factor Filing 5-17-10.pdf |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *BCBS-126629620* | *State:* | *Rhode Island* |
| *Filing Company:* | *Blue Cross & Blue Shield of Rhode Island* | *State Tracking Number:* | |
| *Company Tracking Number:* | *GM-201005* | | |
| *TOI:* | *H15G Group Health - Hospital/Surgical/Medical Expense* | *Sub-TOI:* | *H15G.001 Any Size Group* |
| *Product Name:* | *Group Commercial Medical* | | |
| *Project Name/Number:* | *Group Commercial Rating Factors for 2011/GM-201005* | | |

amendments GRPAMEND (01/09) and GRPAMEND (01/10)

Blue Cross Blue Shield of Rhode Island
500 Exchange Street, Providence, Rhode Island 02903-2699
(401) 459-1000 www.BCBSRI.com

May 17, 2010

Mr. Christopher F. Koller
Health Insurance Commissioner
Office of Health Insurance Commissioner
1511 Pontiac Avenue, Bldg. 69-1
Cranston, Rhode Island 02920

Subject: 1) Rating Factors Applicable to Small Group Subscription Rates for New and Renewal Business Effective January 1, 2011 through December 1, 2011;

2) Rating Factors Applicable to Rhode Island Builders Association Subscription Rates for New and Renewal Business Effective November 1, 2011;

3) Rating Factors Applicable to Large Group Subscription Rates for New and Renewal Business Effective January 1, 2011 through December 1, 2011, including Required Early Notice Accounts Effective January 1, 2012 (Forms on file)

Dear Commissioner Koller:

This letter and the attached documents comprise a rate factor filing by Blue Cross & Blue Shield of Rhode Island (BCBSRI or Blue Cross) of claims projection trends, reserve contribution factors, and related rating information to be used in group commercial rating for the upcoming calendar year.

**Filing Overview**

This rate filing reflects the escalating cost of medical care. Reasons for these increasing costs include medical provider price increases, expensive new technology, increases in the cost of prescription medications and a general increase in the number of medical services obtained by our members. The ongoing increase in costs results in higher medical care cost projections into the future, which translate to higher health insurance premiums. For every group premium dollar paid to Blue Cross, about 84 cents is expected to pay hospitals, physicians and other healthcare providers.

Recent regulatory decisions to reduce rating trends and/or ignore existing rate inadequacies have resulted in insufficient premium levels for the benefits being provided. Thus, BCBSRI continues to incur financial losses and draw down its contingency reserves. Average rate increases less than or equal to claims trend will not be sufficient to stop these losses and will further endanger the financial stability of BCBSRI.

BCBSRI is taking aggressive steps to reduce both claims and administrative costs. On the claims side, BCBSRI has identified significant opportunities for claims savings from increased efficiency in care delivery and adjustments to provider reimbursement. We have also set aggressive targets for additional claims reduction.

This filing proposes administrative charges below currently approved levels as measured on a percent of premium basis. As demonstrated in Exhibit V of this filing, our proposed administrative charges are below industry norms. Blue Cross continues to look inward at our operations to ensure they are as efficient as possible without sacrificing the high quality service we provide to our customers. In the past two years Blue Cross has eliminated 157 full-time positions, eliminated salary increases in 2009 for all employees, eliminated executive salary increases for 2009 and 2010 and increased employee benefit contributions. Despite inflation, our operating budget for 2010 is four percent less than it was in 2007. Additionally, our new headquarters is expected to save $25 million over the next 23 years in comparison to renovating our old locations. Our proposed administrative charges are appreciably below our current expense run rate. We are committing ourselves to close this gap through further efficiency improvements. There is a major company wide effort underway to further reduce our administrative costs.

BCBSRI agrees that the healthcare system needs to change and is intensifying efforts to moderate long-term healthcare costs by transforming the local healthcare delivery system. BCBSRI recognizes that members and employer groups will not be able to continue to afford health insurance if medical costs and the resulting premiums continue to increase at the current pace. The company is already taking bold steps to aggressively transform its business strategy with the intent of improving internal operations, the local healthcare delivery system, and members' health, which will ultimately moderate long-term costs.

Blue Cross experienced heavy financial losses in 2009, causing our reserves to fall in excess of $100 million since the end of 2008, or over 25% of its value. This means Blue Cross now has only enough reserves to pay claims for 63 days, which puts the Corporation at increased risk of insolvency. The current level of reserves has fallen well below the safety ranges recommended by several actuarial studies conducted by independent nationally recognized firms, including one commissioned by the Office of the Health Insurance Commissioner (OHIC).

We therefore request approval to increase reserve contribution factors to a total of 3% of premium, with 1% designated to long term funding of the above-mentioned capital projects. The reasons for this are discussed further in Exhibits I and II of this filing.

**Filing Fee**

In accordance with the filing fee requirements contained in Section 42-14-18 of the General Laws of Rhode Island, an electronic funds transfer (EFT) transaction in the amount of $125 is submitted via the SERFF system. Policy forms pertaining to this filing are as follows:

- HMC2C SA (01/08) and amendments GRPAMEND (01/09) and GRPAMEND (01/10)
- Classic SA (01/08) and amendments GRPAMEND (01/09) and GRPAMEND (01/10)
- BlueCHiP SA (01/08) and amendments GRPAMEND (01/09) and GRPAMEND (01/10)
- HM HDHP SA (01/08) and amendments GRPAMEND (01/09) and GRPAMEND (01/10)
- SO PPO SA (01/08) and amendments GRPAMEND (01/09) and GRPAMEND (01/10)

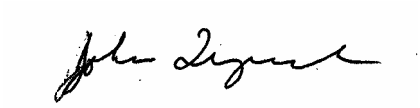
**Conclusion**

Exhibits displaying the required rating factors and detailed actuarial support documenting the factors are enclosed, including those prescribed pursuant to your Office's filing instructions letter of April 20, 2010. The exhibits and attachments for this filing are listed at the end of this letter.

The actuarial assumptions underlying this filing have been developed by my staff and reviewed by myself. I certify that this rate filing was developed utilizing sound actuarial assumptions and methodologies.

We respectfully ask for your timely consideration and approval of the proposed rating factors as submitted. Blue Cross & Blue Shield of Rhode Island believes that the proposed rating factors are in the best interest of both the public and the Corporation and consistent with the proper conduct of our business. As always, we shall be pleased to respond promptly to any questions you, your staff, or your office's consulting actuary, Mr. DeWeese, may have.

Sincerely,



John Lynch, F.S.A., M.A.A.A.
Chief Actuary

Attachments:

Exhibit I, *Actuarial Assumptions for Group Commercial Rating,* outlines the underlying methodology and assumptions used to develop the claims projection trends and reserve contribution factors.

Exhibit II, *BCBSRI Group Reserve Contribution Requirements*, provides further justification for the requested reserve contribution factors.

Exhibit III, *Large Group and Small Group Rate Factor Template* as prescribed by OHIC.

Exhibit IV, *Administrative Costs Documentation*

Exhibit V, *Industry Comparables,* compares the requested trends and administrative loads to benchmarks established by national surveys of health carriers.

Exhibit VI, *Provider Contracting Practices Survey*

Exhibit VII, *Resources for Health System Improvements Survey*

cc: Ms. Monica Neronha, Esquire

# BLUE CROSS & BLUE SHIELD OF RHODE ISLAND

## ACTUARIAL ASSUMPTIONS FOR GROUP COMMERCIAL RATING

### Applicable Group Rate Effective Dates

- Small Group new and renewal business for rating periods commencing January 1, 2011 through December 1, 2011
- Rhode Island Builders Association new and renewal business for the rate period commencing November 1, 2011
- Large Group new and renewal business for rating periods commencing January 1, 2011 through December 1, 2011, including required Early Notice accounts Effective January 1, 2012

### Utilization Projections

The determination of the projection trends contained in this filing reflects the Corporation's standard methodology for **Surgical/Medical utilization/mix,** and **Prescription Drug price/utilization/mix.** This methodology assumes the annual trend represented by the best-fit linear regression line, based on the percentage rate of increase for the period January 2009 through December 2009 over the period January 2008 through December 2008 and continuing into the future in a geometric progression so that the actual trend (percentage increase) is constant over time.

For **Hospital Inpatient utilization**, the days per thousand rate has wavered between a slight decrease and a slight increase over the last year, with a slight decrease in the most recent analysis. None of the regressions using days per thousand data meet our minimum acceptable standards for fit using the standard methodology. We have observed recent significant increases in the rates of out-of-state days per thousand (1.4%) and admissions per thousand (8.5%), which is likely attributable to the growing percentage of BCBSRI enrollment that resides out-of-state.

Hospitals are being converted, and will continue to convert, their inpatient reimbursement basis from per-diem to per-case. Our standard trending methodology applied to admissions per thousand data produces poor-fitting regressions that indicate slightly positive trends. In consideration of the reasons above, it is our actuarial judgment to use a hospital inpatient utilization trend of +1.0%, the same as that submitted in our most recent filing.

For **Hospital Inpatient mix** trend, we performed several measures of depriced cost/day and depriced cost/admission with some results indicating small increases and other results indicating small decreases, with no predominant outcome. Therefore it is our actuarial judgment to use a 0.0% inpatient annual mix adjustment, the same as that submitted in the most recent filing.

For **Hospital Outpatient utilization/mix** trend, we continue to experience a significant upswing. Part of this is a result of increased rates of day surgery both in Rhode Island hospitals and in neighboring states, as well as an increase in lab costs. We have also seen increased use of very high cost cancer therapies both in- and out-of-state, high costs for these therapies at some Boston teaching hospitals, and a growing percentage of enrollment that resides out-of-state. The standard methodology line of best fit is based on the last 20 points and represents a calculated annual trend of 6.76%. For the reasons cited above, we believe outpatient trends will continue at historically high levels, but we have decided to moderate the calculated trend value. It is our actuarial judgment to use an annual trend of 5.18%, the same as that submitted in our most recent filing.

**Utilization/mix trends for Primary Care and Other Medical/Surgical** were determined on a combined basis as one Surgical/Medical utilization/mix trend, consistent with our customary practice in previous filings. The determination of separate trends continues to produce results that are not credible, and the resulting combined trend result is judged to be a reasonable expectation for both segments. Many areas of physician and ancillary utilization have shown increases; most notably, visits to primary care and specialist physicians are up 3-5% over the last year, which appear to be driving increased use of lab testing and other ancillary services.

For **Major Medical**, the projection factor has been determined by a meld of Surgical/Medical price/utilization/mix trend and Large Group Prescription Drug price/utilization/mix trend, consistent with an analysis of the percentage of Major Medical group claims in each category.

For **Prescription Drugs price/utilization/mix**, separate trends were determined for Large Groups and Small Groups based on the predominant copayment configuration sold in each segment ($7/$25/$40/$40 for Large Groups; $7/$30/$50/$75 for Small Groups).

Price Projections

**Hospital** price projections reflect estimated hospital price increases based on existing reimbursement contracts and anticipated payment levels in the future.

The **RI Primary Care** price projections reflect the provider fee adjustments required by the OHIC Primary Care Spend standard.

The **Other Medical/Surgical** projection trends reflect a series of provider fee adjustments and initiatives through the subject rating periods.

Reserve Contribution Factor

The reserve contribution factors in this filing are 3.0% for both small and large group accounts, consisting of a 2.0% baseline contribution plus 1.0% to fund capital projects. These factors are filed with the objective of gradually rebuilding corporate reserves to ensure the financial viability and stability of Blue Cross & Blue Shield of Rhode Island for the future, and compliance with Risk Based Capital requirements of the Blue Cross and Blue Shield Association.

These factors include an additional 0.5% which is intended to recoup extraordinary expenses necessitated by the installation of a new BCBSRI core operational computer system over the span of its anticipated useful life. These expenses have been excluded from our administrative charge determinations. A special reserve contribution component for this purpose has been approved in prior BCBSRI rate filings.

BCBSRI also proposes to implement an additional 0.5% load to assist in funding our Integrated Health Management (IHM) project. Our IHM initiative aims at transforming BCBSRI from a health insurer to a health management company and will incorporate multiple approaches including benefit design and incentives, enhanced member engagement and communication, and significant provider engagement and incentives. As with the new core operational computer system project referenced above, the costs of this initiative are being excluded from development of our administrative charges. However given the deterioration in our reserve position we now consider it prudent to implement some current charges to partially fund this project. Note that we expect that a significant

portion our total IHM investment will be recouped out of the net savings we anticipate will be generated in future years.

Please refer to Exhibit II, "BCBSRI Group Reserve Contribution Requirements," for further discussion and justification of our reserve contribution factors submitted in this filing.

Administrative Expense

Please refer to the enclosed documents "Administrative Costs Documentation" (Exhibit IV) and "Industry Comparables" (Exhibit V) for explanation and justification of the administrative charge rate components shown in Exhibit III. Administrative charges set forth in these documents include provisions for broker commissions, federal income taxes, and state premium tax. State assessments on the Corporation resulting from Comprehensive Evaluation, Diagnosis, Assessment, Referral and Re-evaluation (CEDARR), Child Intervention Services and Home Services, the State Child Immunization Fund, and adult influenza vaccine are now incorporated into projected claims costs as per the instruction of OHIC.

There is currently a gap between our proposed administrative charges and projected cost levels. Despite this, we propose to reduce the administrative charges below levels actually in current rates measured as a percent of premium. Our intention is to seek to close the gap through expense reduction efforts rather than increases in future charge levels. Toward that end we have launched a new quality and efficiency improvement effort, the Continuous Improvement initiative, which we expect will result in expense savings.

While we are committing ourselves to do our utmost to limit future escalation in our administrative charges to CPI type levels, it is in no one's best interests that we under-fund programs designed to improve the efficiency of the health care system and the quality of patient outcomes. Accordingly we plan on submitting a proposal aimed at reclassifying as medical expenses certain costs that are currently classified as administrative expense.

Projected Average Rate Increases

Average rate increase values displayed on page 3 of Exhibit III are current estimates utilizing the latest available claims experience base. Actual rates for the subject rating periods will be determined using updated claims experience, and thus the resulting average rate increases are not guaranteed.

# Blue Cross & Blue Shield of Rhode Island

## Group Reserve Contribution Requirements

Blue Cross & Blue Shield of Rhode Island (BCBSRI) has had actuarial studies done by two different nationally recognized actuarial firms to develop a target reserve range. These studies, updated in 2003, resulted in consistent recommendations; shown below as a percent of premium

- Study 1: 26% or higher
- Study 2: 25% - 35%

More recently, the Lewin Group was commissioned by the Office of the Health Insurance Commissioner (OHIC) to perform such a study. That study, as with the others, identified the common risks inherent to all plans providing health insurance in the United States.

These include:

- Medical price inflation
- New technologies
- Changing utilization patterns
- Presence and power of competitors
- Capital adequacy, which is different for non-profits versus for-profits
- The insurers' mix of business
- Catastrophic events, including pandemics

Additionally, there are unique risks for BCBSRI, including:

- Geographic business limitations, in which the company can not use the Blue brands to sell insurance outside of Rhode Island
- Its policies of pricing its products with small margins
- Its non-profit status, which means that it is not open to capital markets
- The fact that BCBSRI is statutorily defined as a charitable corporation, which creates greater public scrutiny
- A regulatory environment that limits premium rate increases

As a result of their analysis, the Lewin Group recommended BCBSRI's target reserve level to be in the range of 23 to 31 percent of premium—again, consistent with the most recent studies identified above.

***Appropriate reserve levels***

Appropriate reserve levels are needed for a number of reasons, but most important, to protect BCBSRI members. That's why the BCBSRI's reserves must be at a level to withstand a multi-year unfavorable business cycle. There can be, and often are, many different factors that cause an unfavorable business cycle. The most significant is related to predicting the cost of future medical services.

At this point, BCBSRI is facing many challenges, including:

- An economic recession, which is putting strain on Rhode Island's healthcare system
- A rapidly growing uninsured population
- New competition
- Decreasing enrollment
- Increasing healthcare medical trends
- Increasing total premium must be supported by additional reserves
- Emerging higher medical trends than those inherent in rates, resulting in year-to-date (March) underwriting losses
- The Centers for Medicare and Medicaid Services (CMS) cutbacks in Medicare Advantage reimbursement
- Government healthcare reform

While BCBSRI feels the Lewin Group's reserve range of 23 to 31 percent is reasonable, the minimum of 23 percent is insufficient to protect members during an unfavorable business cycle. BCBSRI believes it must manage reserves toward the midpoint of the appropriate reserve range (27% of premium). This is needed in order to adequately protect its members in the event of a multi-year unfavorable business cycle.

***Current financial results***

BCBSRI has observed negative financial results through March, 2010, and anticipates that this negative trend will continue through the end of the year and beyond. To date, there are significant underwriting losses in the Small Group and Large Group fully insured markets. These losses are attributed to actual medical claims trends being higher than those inherent in the current premium rates.

To date, these results have already had a significant impact on BCBSRI's reserves. Reserves were 23.5% of premium as of December 31, 2008, but have fallen to 16.8% of premium as of March 31, 2010.

This is a serious concern, particularly considering the converging challenges identified earlier.

***Current rate filing***

With all of this in mind, BCBSRI is filing a 2 percent baseline contribution to reserves for Small Group and Large Group. Consistent with previous filings, BCBSRI is adding a contribution load to amortize the cost of developing and implementing a new core computer processing system. This charge will be set to 0.5 percent, and will continue until the cost of the system has been fully recouped.

Additionally, a 0.5 percent contribution load has been added to fund a portion of our Integrated Health Management (IHM) project. Through IHM we are working to significantly transform the way we interact with our members, healthcare practitioners, and our group customers to produce better outcomes, healthier lives and lower costs. Given the dramatic reduction in BCBSRI's reserve position, this project can no longer be wholly funded from reserves.

Thus, the total reserve component in this filing is 3.0 percent for Small Group and Large Group. This includes the baseline contribution of 2.0 percent plus 1.0 percent to fund capital projects.

***Conclusion***

Several actuarial studies produced similar reserve range targets. BCBSRI's current reserve level is below the minimum of all of these ranges. BCBSRI faces a number of challenges today. Given these challenges—along with current and projected financial results in the fully insured markets, as well as the unknown of government healthcare reform—it is critical that BCBSRI have an adequate reserve level.

**Small/Large Group Rate Filing Template**

**Historical Information**

**Experience Period for Developing Rates**

| | From | To |
|---|---|---|
| Trends: | 1/1/2007 | 12/31/2009 |
| Small Group & RI Builders Rate Increase Estimates: | 1/1/2009 | 12/31/2009 |
| Large Group Rate Increase Estimates: | 12/1/2008 | 11/30/2009 |

Utilization/Experience Data by Quarter (Last 12 available quarters)

| Quarter | End Date | IP Days | Member Months | Earned Premium | Incurred Claims Total[1] | Incurred Claims IP | Incurred Claims OP | Incurred Claims Primary Care | Incurred Claims Other M/S | Incurred Claims Major Medical | Incurred Claims Rx | Loss Ratio |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 (oldest) | 3/31/2007 | 21,263 | 791,279 | $258,862,939 | $228,825,021 | $52,251,669 | $50,029,179 | $9,063,045 | $75,393,963 | $803,861 | $39,161,734 | 88.4% |
| 2 | 6/30/2007 | 20,457 | 793,811 | $262,389,355 | $226,896,687 | $48,943,493 | $51,063,798 | $8,495,595 | $76,632,807 | $1,001,938 | $38,823,475 | 86.5% |
| 3 | 9/30/2007 | 21,963 | 802,253 | $266,482,843 | $226,882,037 | $52,186,389 | $49,806,681 | $8,989,664 | $74,625,513 | $994,661 | $38,990,417 | 85.1% |
| 4 | 12/31/2007 | 21,228 | 805,086 | $270,448,612 | $230,813,340 | $50,829,211 | $51,609,150 | $9,382,073 | $76,209,137 | $971,867 | $40,099,720 | 85.3% |
| 5 | 3/31/2008 | 20,530 | 762,063 | $265,113,667 | $225,026,455 | $50,367,657 | $50,373,302 | $9,154,951 | $73,333,393 | $702,742 | $39,416,084 | 84.9% |
| 6 | 6/30/2008 | 19,584 | 738,663 | $259,988,463 | $220,989,580 | $50,214,057 | $49,978,503 | $8,733,203 | $72,655,714 | $755,126 | $38,387,286 | 85.0% |
| 7 | 9/30/2008 | 17,754 | 704,528 | $247,846,973 | $208,394,825 | $45,281,787 | $48,190,581 | $8,339,713 | $66,703,926 | $462,427 | $37,140,519 | 84.1% |
| 8 | 12/31/2008 | 18,896 | 705,678 | $251,517,367 | $219,300,585 | $49,666,077 | $50,454,299 | $8,640,519 | $69,221,737 | $269,319 | $38,835,099 | 87.2% |
| 9 | 3/31/2009 | 18,779 | 669,774 | $245,007,740 | $209,767,343 | $47,563,220 | $50,105,739 | $8,219,268 | $64,492,441 | $113,264 | $36,685,059 | 85.6% |
| 10 | 6/30/2009 | 17,807 | 664,622 | $246,275,386 | $218,560,214 | $49,448,930 | $51,978,621 | $8,350,791 | $69,266,185 | $127,954 | $36,845,125 | 88.7% |
| 11 | 9/30/2009 | 16,270 | 650,631 | $240,428,534 | $209,338,346 | $45,379,893 | $50,110,493 | $8,762,599 | $65,955,502 | $111,540 | $36,065,272 | 87.1% |
| 12 | 12/31/2009 | 15,670 | 645,560 | $240,893,824 | $206,039,536 | $41,845,001 | $49,237,458 | $9,461,068 | $65,504,130 | $127,263 | $36,752,991 | 85.5% |

| Quarter | End Date | Cost Containment Expense[2] | Other Claim Adjustment Expense[2] | General Administrative Expense[2] | Commissions | Rx Rebates | Premium Deficiency Reserve | Other[3] | Operating Gain/(Loss) |
|---|---|---|---|---|---|---|---|---|---|
| 1 (oldest) | 3/31/2007 | $3,284,703 | $8,313,824 | $16,186,479 | $4,433,124 | ($3,719,997) | $0 | ($6,152,125) | ($4,612,340) |
| 2 | 6/30/2007 | $3,474,710 | $8,794,745 | $18,117,530 | $4,668,601 | ($4,104,558) | $0 | ($6,357,062) | ($1,815,423) |
| 3 | 9/30/2007 | $3,590,448 | $9,087,688 | $20,291,696 | $4,318,803 | ($2,034,328) | $0 | $3,975,911 | $8,322,411 |
| 4 | 12/31/2007 | $3,493,797 | $8,579,130 | $21,295,494 | $4,525,050 | ($2,149,851) | $0 | $6,919,182 | $10,810,833 |
| 5 | 3/31/2008 | $3,404,415 | $8,616,826 | $20,501,640 | $5,043,497 | ($3,593,498) | $0 | ($4,549,761) | $1,564,571 |
| 6 | 6/30/2008 | $3,550,261 | $8,985,971 | $20,194,105 | $4,140,933 | ($1,276,514) | $0 | $860,979 | $4,265,107 |
| 7 | 9/30/2008 | $3,668,393 | $9,284,971 | $20,897,742 | $4,247,023 | ($2,139,135) | $0 | $4,808,738 | $8,301,891 |
| 8 | 12/31/2008 | $3,312,193 | $10,313,470 | $25,994,266 | $4,720,010 | ($3,708,768) | $0 | $4,309,003 | ($4,105,385) |
| 9 | 3/31/2009 | $4,373,078 | $11,068,580 | $24,995,635 | $4,979,348 | ($998,865) | $0 | ($2,069,461) | ($11,246,840) |
| 10 | 6/30/2009 | $4,506,031 | $11,405,095 | $25,146,269 | $4,402,964 | ($4,104,558) | $25,100,000 | $1,072,798 | ($37,667,831) |
| 11 | 9/30/2009 | $4,542,967 | $11,498,583 | $25,188,532 | $4,602,917 | ($2,034,328) | $39,400,000 | ($4,686,277) | ($56,794,758) |
| 12 | 12/31/2009 | $3,930,245 | $12,462,110 | $28,196,645 | $4,416,947 | ($2,149,851) | $23,700,000 | ($3,853,289) | ($39,555,096) |

| Quarter | End Date | Investment Income | Other Income/ (Expense) | Taxes | Net Gain/(Loss) |
|---|---|---|---|---|---|
| 1 (oldest) | 3/31/2007 | $5,274,593 | ($288,800) | $376,359 | ($2,906) |
| 2 | 6/30/2007 | $4,564,873 | $1,681,200 | $1,126,502 | $3,304,149 |
| 3 | 9/30/2007 | $4,646,273 | $41,416 | $3,019,822 | $9,990,277 |
| 4 | 12/31/2007 | $4,479,496 | ($20,737,380) | $925,140 | ($6,372,191) |
| 5 | 3/31/2008 | $4,689,615 | ($3,347,065) | $818,109 | $2,089,012 |
| 6 | 6/30/2008 | $4,009,850 | ($2,702,648) | $2,189,687 | $3,382,621 |
| 7 | 9/30/2008 | $2,812,761 | ($2,234,974) | $2,030,389 | $6,849,290 |
| 8 | 12/31/2008 | ($6,480,981) | ($7,537,216) | ($4,091,902) | ($14,031,680) |
| 9 | 3/31/2009 | $2,190,769 | $554,193 | ($1,772,637) | ($6,729,241) |
| 10 | 6/30/2009 | $4,534,922 | $1,599,148 | $901,678 | ($32,435,438) |
| 11 | 9/30/2009 | $3,570,630 | $1,650,811 | ($6,542,191) | ($45,031,127) |
| 12 | 12/31/2009 | $352,397 | $1,153,861 | $854,391 | ($38,903,228) |

[1] Includes State Assessments

[2] These categories conform generally to the reporting in the NAIC statement (excluding Direct Pay and including Federal Employees Health Benefit Program).

[3] Includes changes in premium and claims accruals, bad debt and other unreconciled items.

Differences from data reported in the prior filing are due to accrual adjustments, retroactivity, and inclusion of capitated payments to primary care physicians for the CHiP product.

# Blue Cross & Blue Shield of Rhode Island

**Small/Large Group Rate Filing Template**

**Prospective Information**

Trend Factors for Projection Purposes (Annualized)

| 2011/2010 | | | | | | | |
|---|---|---|---|---|---|---|---|
| | IP | OP | Primary Care | Other M/S | Major Medical | Small Group Rx | Large Group Rx |
| **Total** | ***9.69%*** | ***13.42%*** | ***13.51%*** | ***7.34%*** | ***9.07%*** | ***10.64%*** | ***10.05%*** |
| **Price Only** | 8.60% | 7.83% | 8.19% | 2.31% | | | |
| **Utilization[(1)]** | 1.00% | 5.18% | 4.92% | 4.92% | | | |
| **Mix[(2)]** | 0.00% | | | | | | |

| 2012/2011 | | | | | | | |
|---|---|---|---|---|---|---|---|
| | IP | OP | Primary Care | Other M/S | Major Medical | Small Group Rx | Large Group Rx |
| **Total** | ***7.05%*** | ***11.30%*** | ***13.23%*** | ***7.99%*** | ***9.33%*** | ***10.64%*** | ***10.05%*** |
| **Price Only** | 5.99% | 5.82% | 7.92% | 2.93% | | | |
| **Utilization[(1)]** | 1.00% | 5.18% | 4.92% | 4.92% | | | |
| **Mix[(2)]** | 0.00% | | | | | | |

(1) Utilization trend also incorporates Mix for Outpatient, Primary Care, and Other M/S.
Major Medical and Rx trends are in total only, not broken down into Price, Utilization, and Mix.

(2) Inpatient Mix is the measure of the effect on average cost per unit of changes in average intensity of service, type of service, and and hospital provider.

# Blue Cross & Blue Shield of Rhode Island

**Small/Large Group Rate Filing Template**

**SMALL GROUP**

| Quarter | Beginning Date | Estimated Average % Rate Increase[1] | Expected Medical Loss Ratio | Expected Contribution to Reserves[2] | Operating Expense Charge % | Estimated Average Commissions% |
|---|---|---|---|---|---|---|
| 1 | 1/1/2011 | 14.3% | 83.5% | 3.00% | 10.8% | 2.7% |
| 2 | 4/1/2011 | 13.5% | 83.5% | 3.00% | 10.8% | 2.7% |
| 3 | 7/1/2011 | 10.3% | 83.5% | 3.00% | 10.8% | 2.7% |
| 4 | 10/1/2011 | 11.3% | 83.5% | 3.00% | 10.8% | 2.7% |

**LARGE GROUP**

| Quarter | Beginning Date | Estimated Average % Rate Increase[1] | Expected Medical Loss Ratio | Expected Contribution to Reserves[2] | Operating Expense Charge % | Estimated Average Commissions% |
|---|---|---|---|---|---|---|
| 1 | 1/1/2011 | 12.9% | 85.5% | 3.00% | 10.3% | 1.2% |
| 2 | 4/1/2011 | 14.6% | 85.5% | 3.00% | 10.3% | 1.2% |
| 3 | 7/1/2011 | 13.6% | 85.5% | 3.00% | 10.3% | 1.2% |
| 4 | 10/1/2011[3] | 12.6% | 85.5% | 3.00% | 10.3% | 1.2% |

**RHODE ISLAND BUILDERS**

| Quarter | Beginning Date | Estimated Average % Rate Increase[1] | Expected Medical Loss Ratio | Expected Contribution to Reserves[2] | Operating Expense Charge % | Estimated Average Commissions% |
|---|---|---|---|---|---|---|
| 1 | 11/1/2011 | 13.3% | 83.6% | 3.00% | 10.7% | 2.7% |

[1] Rate Increases are estimated based on current experience and rates. Actual increases will differ due to use and and consideration of updated experience, cancellations, new business, etc.

[2] Reserve contribution includes 2% baseline plus 1% to aid in the funding of ongoing capital projects.

[3] Includes January 2012 early notice renewals that utilize the same claim experience periods.

1. The following table illustrates 2010 approved and 2011 requested small and large group administrative charges (pmpm):

| | 2010 q3/q4 Approved | | 2011 Proposed | | % Change | |
|---|---|---|---|---|---|---|
| | Small Group | Large Group | Small Group | Large Group | Small Group | Large Group |
| Total Estimated Member Months | 749,144 | 1,517,318 | 738,079 | 1,532,292 | -1.5% | 1.0% |
| Total Estimated Premiums ($pmpm) | $449.29 | $418.89 | $481.78 | $465.00 | 7.2% | 11.0% |
| Operating Expense Charge ($pmpm) | $50.53 | $44.55 | $51.82 | $47.96 | 2.6% | 7.7% |
| Average Broker Commission ($PMPM) | $12.46 | $5.78 | $13.24 | $5.54 | 6.3% | -4.2% |
| Total Filed OE ($PMPM) | $62.99 | $50.33 | $65.06 | $53.50 | 3.3% | 6.3% |
| | | | | | | |

2011 Proposed expense charges are well below our anticipated expenses at this time. Therefore allocating these charges into NAIC defined categories is not meaningful.

2. The following table details the actual administrative costs pmpm, allocated among the NAIC-approved administrative cost categories:

| Fully Insured Commercial Administrative Cost History (Comprehensive Column) | | | | | |
|---|---|---|---|---|---|
| | 2005 | 2006 | 2007 | 2008 | 2009 |
| Total Fully Insured Member Months | 3,362,689 | 3,393,617 | 3,326,346 | 3,049,827 | 2,775,423 |
| Total Premiums | 1,015,326,220 | 1,074,800,337 | 1,108,466,606 | 1,079,151,863 | 1,025,508,205 |
| Total General Administrative Expense | 81,917,481 | 86,531,511 | 100,746,665 | 121,463,184 | 132,106,574 |
| Total Cost Containment Expense | 14,512,208 | 14,014,454 | 13,626,905 | 13,099,379 | 15,908,854 |
| Total Other Claim Adjustment Expense | 25,050,767 | 30,331,998 | 33,465,022 | 40,796,083 | 50,472,000 |
| Total Administrative Expenses | 121,480,456 | 130,877,962 | 147,838,593 | 175,358,646 | 198,487,429 |
| Total Admin Exp. Ratio | 11.96% | 12.18% | 13.34% | 16.25% | 19.36% |
| Total Administrative Expense ($pmpm) | $36.13 | $38.57 | $44.44 | $57.50 | $71.52 |
| Core System Replacement | $0.00 | $0.00 | $0.00 | $16,300,000 | $27,847,000 |
| | | | | | |
| Breakdown of General Administrative Expenses ($ pmpm) | | | | | |
| a. Payroll and benefits | $13.56 | $14.69 | $17.53 | $17.40 | $21.04 |
| b. Outsourced Services (EDP, claims | $5.98 | $6.81 | $9.28 | $8.93 | $8.62 |
| c. Auditing and consulting | $2.00 | $2.09 | $2.20 | $5.75 | $6.38 |
| d. Commissions | $5.00 | $5.43 | $5.49 | $6.06 | $6.78 |
| e. Marketing and Advertising | $0.91 | $0.83 | $0.81 | $0.99 | $0.89 |
| f. Legal Expenses | $1.04 | $0.40 | $1.02 | $0.33 | $0.25 |
| g. Taxes, Licenses and Fees | $0.06 | $0.14 | $0.10 | $3.68 | $7.49 |
| h. Reimbursements by Uninsured Plans | ($11.17) | ($11.39) | ($11.59) | ($12.49) | ($10.76) |
| i. Other Admin Expenses | $6.97 | $6.50 | $5.44 | $9.18 | $6.90 |
| | | | | | |
| Cost Containment Expense | $4.32 | $4.13 | $4.10 | $4.30 | $5.73 |
| Other Claim Adjustment Expense | $7.45 | $8.94 | $10.06 | $13.38 | $18.19 |
| | | | | | |
| Total Self Insured Member Months for all affiliated companies doing business in RI | 2,312,002 | 2,409,639 | 2,474,355 | 2,677,918 | 2,448,365 |

* Administrative cost history ties exactly to our NAIC filings which includes Direct Pay and excludes Federal Employees

3. At the request of OHIC's Health Insurance Advisory Council, please provide brief answers to the following questions:

a. In general and net of new taxes and fees, why should the rate of increase in Health Plan administrative costs exceed the general inflation rate?
*There are a number of reasons why Health Plan Administrative Expenses might increase at a pace greater than the general rate of inflation. Major corporate infrastructure upgrades, such as the implementation of new information technology systems and the modification of operating processes, procedures and systems to comply with new Government mandates (i.e. HIPAA, ICD 10, Federal Healthcare Reform and Medicare Regulations), can add significantly to the level of Administrative Expenses incurred in any particular year.*

*In addition, significant drops in membership, as occurred in 2009 due to unfavorable economic conditions, can have a material impact on the level of Administrative Expenses on a per member per month basis as many Administrative Expenses are fixed in nature and don't decrease as enrollment decreases.*

b. What percentage of administrative costs does your organization consider fixed for the next five years? Provide detail by expense category.
*About 60% of the expenses are fixed. We can provide details assuming the following items are variable: Staff costs for Customer/Provider Service, Medical Management, Actuarial & Underwriting Services, Marketing, Grievance & Appeals, Vendor Fees (Claims and Enrollment), Broker Commisssions, Printing & Postages and BlueCard/ Consortium Fees.*

c. What administrative services are used by fully insured members that are not used by self-insured clients (e.g. broker commissions) and what are the estimated total costs ($pmpm) for those services?
*The self-insured clients use most of the same services that our fully insured customers use except for Broker Commission and Underwriting. The average size of the self-insured groups is substantially higher than the fully insured customers which means that many of the expense categories will naturally cost less on a per member basis. Also, premium taxes are not charged to self-insured groups.*

d. What does your plan use as its pmpm benchmarks or price points for commercial insurance administrative costs and why?

*There are a number of considerations that go into deciding on the level of administrative charges to be built into rates. The first of course is our actual expense level. In the current circumstances we are incurring significant expenses associated with the development and installation of a new core computer system. We call this project BlueTransIT. As discussed in prior filings we are not attempting to fully build these expenses into current rates but instead are amortizing these development costs over the expected useful life of the system. We feel this approach is more equitable to current customers and also a practical necessity for competitive reasons. Additionally we are expending significant monies with our Integrated Health Management (IHM) initiative. This is an effort aimed at transforming the local health care system and is expected to produce significant long term savings in medical expenses and also better health outcomes for our members. However since current costs exceed current savings we have decided that we should not build these expenses into the administrative charges we use in rating. So Blue TransIT and IHM costs are not recognized in rating other than through the 100 basis point component included in our proposed reserve contribution factor.*

*Even after excluding the expenses for the two major projects discussed above our expense levels are beyond what we consider a competitive level and beyond the level we believe we should be striving to hit. So rather than set our pricing assumptions at our actual expense levels, we have elected to set our administrative charge levels at what we consider appropriate marketplace levels and to work at finding operational efficiencies to close the gap between our pricing and actual expenses. The administrative charge levels included in this filing reflect some cost escalation over the levels in current rates but a less than medical trend increase. Our proposed charges are also well in line with prevailing industry averages as measured on a percent of premium basis. This is demonstrated in Exhibit V where we compare our proposed charge levels to national average charge levels reported in a recent American Academy of Actuaries study.*

# Blue Cross & Blue Shield of Rhode Island

Industry Comparables

## 1. Industry Comparables: Trends

| Trend Comparison | | | |
|---|---|---|---|
| | **Medical** | **Drug** | **Total** |
| **BCBSRI Filed Trend 2011/2010** | | | |
| **Large Group** | **10.0%** | **10.1%** | **10.0%** |
| **Small Group** | **10.0%** | **10.6%** | **10.1%** |
| **BCBSRI Filed Trend 2012/2011** | | | |
| **Large Group** | **9.0%** | **10.1%** | **9.2%** |
| **Small Group** | **9.0%** | **10.6%** | **9.3%** |
| | | | |
| BCBSRI Trend Approved Mar-2010 for 2010 | | | |
| Large Group | 8.8% | 10.3% | 9.1% |
| Small Group | 8.8% | 11.0% | 9.3% |
| | | | |
| United Trend Approved Mar-2010 for 2010 | | | |
| Large Group | 10.0% | 10.8% | 10.1% |
| Small Group | 10.1% | 9.9% | 10.1% |
| | | | |
| Tufts Trend Approved Sep-2009 for 2010 | | | |
| Large & Small Group | 9.7% | 10.1% | 9.8% |
| | | | |
| Survey PPO Trends | | | |
| Oliver Wyman Survey [2] | 11.0% | 12.6% | 11.3%[1] |
| Aon Consulting Survey [3] | 11.0% | 9.3% | 10.7% |
| Segal Survey [4] | 10.8% | 9.1% | 10.5% |
| Average of National Surveys[5] | 10.9% | 10.3% | 10.8% |

[1] Melded using current BCBSRI weights
[2] Oliver Wyman Survey trend for January 2010 rating
[3] Aon Consulting Survey trend for July 2009 rating
[4] Segal Survey trend for January 2010 rating
[5] Linear average of national surveys

# Blue Cross & Blue Shield of Rhode Island
Industry Comparables

## 2. Industry Comparables: Retention Charges

| | BCBSRI filed | | |
|---|---|---|---|
| | Large Group | Small Group | National Average[1] |
| Standard Administrative Costs | 9.5% | 11.5% | 10.4% |
| State Premium Tax | 2.0% | 2.0% | 2.0%[2] |
| Total Administrative Charge | 11.5% | 13.5% | 12.4% |
| Reserve / Profit Charges | 3.0% | 3.0% | 4% - 8% |
| Total Retention Charges | 14.5% | 16.5% | 16.4% – 20.4% |

(1) From the American Academy of Actuaries, September 2009 "Critical Issues in Health Reform: Administrative Expenses." Expenses include all lines of business. If just fully insured commercial group business were considered, the administrative cost ratio reported above would be higher because both Medicare Advantage and self insured plans have lower charges as a percent of premium.

(2) Uses Rhode Island values for comparability purposes.

Note: The above referenced American Academy of Actuaries report also states: "A typical minimum required surplus level might be 25 percent of premium or more." This statement is consistent with the findings of the actuarial studies cited in Exhibit II.

**Blue Cross & Blue Shield of Rhode Island**

**Large and Small Group Rate Factor Review**

**Survey: Provider Contracting Services**

Part 1. Hospital Inpatient Services

- To be filled out for each general service (no specialty care, no rehab) institution with whom you contract in the state.
- Institution means hospital system if all contractual terms other than $ amounts apply identically across all inpatient facilities in the contract.
- Incentives refer to activities or measures resulting in additional payments by the insurer.

| Institution/ System | Duration of Current Contract from inception (years) | Unit of Payment for Services (check all that apply) | Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments | Are there Quality or Customer Service Incentives in Contract (y/n)[1]? | Utilization Incentives in Contract: (check all that apply) | Does contract have provision for additional payments to attain revenue targets(y/n) and any comments? | Comments |
|---|---|---|---|---|---|---|---|
| 1 | 3 | __ DRG<br>X Per Diem<br>__ % of Charges<br>__ Bundled Services<br>__ Capitation or other budgeting<br>X Others (please specify) Case Rates, Implant Cost | Yes, claims above a specified charge threshold are paid at a percent of charge | If yes - % of total payments for inpatient services in CY 2009 spent on quality incentive payments. [2]<br>0.37% | __ admission reductions<br>__ day reductions<br>__ Others (please specify) | No | |

[1] Examples include supplemental payments beyond base fees for Bridges to Excellence Measure, Medicare Compare measures, HIT adoption, or customer satisfaction measures.

[2] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

| Institution/ System | Duration of Current Contract from inception (years) | Unit of Payment for Services (check all that apply) | Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments | Are there Quality or Customer Service Incentives in Contract (y/n)[1]? | Utilization Incentives in Contract: (check all that apply) | Does contract have provision for additional payments to attain revenue targets(y/n) and any comments? | Comments |
|---|---|---|---|---|---|---|---|
| 2 | 2 | __ DRG<br>__ Per Diem<br>__ % of Charges<br>__ Bundled Services<br>__ Capitation or other budgeting<br>X Others (please specify) Global Liability | No | If yes - % of total payments for inpatient services in CY 2009 spent on quality incentive payments.<br>None | X admission reductions<br>X day reductions<br>X Others (please specify)<br>By nature of the global / fixed reimbursement, provider directly benefits from any efficiencies gained | No | |
| 3 | 2 | X DRG<br>X Per Diem<br>__ % of Charges<br>__ Bundled Services<br>__ Capitation or other budgeting<br>__ Others (please specify) | No | If yes - % of total payments for inpatient services in CY 2009 spent on quality incentive payments.<br>2.0% for 2009, but built into rates as of 10/2009 | __ admission reductions<br>__ day reductions<br>__ Others (please specify) | No | |

| Institution/ System | Duration of Current Contract from inception (years) | Unit of Payment for Services (check all that apply) | Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments | Are there Quality or Customer Service Incentives in Contract (y/n)[1]? | Utilization Incentives in Contract: (check all that apply) | Does contract have provision for additional payments to attain revenue targets(y/n) and any comments? | Comments |
|---|---|---|---|---|---|---|---|
| 4 | 3 | __ DRG<br>X Per Diem<br>X % of Charges<br>__ Bundled Services<br>__ Capitation or other budgeting<br>X Others (please specify) Implant Cost | Yes, claims above a specified charge threshold are paid at a percent of charge | If yes - % of total payments for inpatient services in CY 2009 spent on quality incentive payments.<br>0.37% | __ admission reductions<br>__ day reductions<br>__ Others (please specify) | No | |
| 5 | 2 | __ DRG<br>X Per Diem<br>__ % of Charges<br>__ Bundled Services<br>__ Capitation or other budgeting<br>X Others (please specify) Case Rates | No | If yes - % of total payments for inpatient services in CY 2009 spent on quality incentive payments.<br>3.0% | __ admission reductions<br>__ day reductions<br>__ Others (please specify) | No | |

| Institution/ System | Duration of Current Contract from inception (years) | Unit of Payment for Services (check all that apply) | Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments | Are there Quality or Customer Service Incentives in Contract (y/n)[1]? | Utilization Incentives in Contract: (check all that apply) | Does contract have provision for additional payments to attain revenue targets(y/n) and any comments? | Comments |
|---|---|---|---|---|---|---|---|
| 6 | 4 | __ DRG<br>X Per Diem<br>__ % of Charges<br>__ Bundled Services<br>__ Capitation or other budgeting<br>X Others (please specify) Case Rates | No | If yes - % of total payments for inpatient services in CY 2009 spent on quality incentive payments.<br>0.50% | __ admission reductions<br>__ day reductions<br>__ Others (please specify) | No | |
| 7 | 2 | __ DRG<br>X Per Diem<br>__ % of Charges<br>__ Bundled Services<br>__ Capitation or other budgeting<br>X Others (please specify) Case Rates | No | If yes - % of total payments for inpatient services in CY 2009 spent on quality incentive payments.<br>3.00% | __ admission reductions<br>__ day reductions<br>__ Others (please specify) | No | |

| Institution/ System | Duration of Current Contract from inception (years) | Unit of Payment for Services (check all that apply) | Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments | Are there Quality or Customer Service Incentives in Contract (y/n)[1]? | Utilization Incentives in Contract: (check all that apply) | Does contract have provision for additional payments to attain revenue targets(y/n) and any comments? | Comments |
|---|---|---|---|---|---|---|---|
| 8 | 1 | X DRG<br>X Per Diem<br>__ % of Charges<br>__ Bundled Services<br>__ Capitation or other budgeting<br>__ Others (please specify) | Yes, outlier per diems paid for cases which exceed length of stay parameters | If yes - % of total payments for inpatient services in CY 2009 spent on quality incentive payments.<br>1.0% paid for fy 2009, but built into rates eff 10/09 | __ admission reductions<br>__ day reductions<br>__ Others (please specify) | No | |
| 9 | 3 | __ DRG<br>X Per Diem<br>__ % of Charges<br>__ Bundled Services<br>__ Capitation or other budgeting<br>X Others (please specify) Case Rates, Implant Cost | Yes, claims above a specified charge threshold are paid at a percent of charge | If yes - % of total payments for inpatient services in CY 2009 spent on quality incentive payments.<br>0.37% | __ admission reductions<br>__ day reductions<br>__ Others (please specify) | No | |

| Institution/ System | Duration of Current Contract from inception (years) | Unit of Payment for Services (check all that apply) | Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments | Are there Quality or Customer Service Incentives in Contract (y/n)[1]? | Utilization Incentives in Contract: (check all that apply) | Does contract have provision for additional payments to attain revenue targets(y/n) and any comments? | Comments |
|---|---|---|---|---|---|---|---|
| 10 | 2 | __ DRG<br>__ Per Diem<br>__ % of Charges<br>__ Bundled Services<br>__ Capitation or other budgeting<br>X Others (please specify) Global Liability | No | If yes - % of total payments for inpatient services in CY 2009 spent on quality incentive payments.<br>None | X admission reductions<br>X day reductions<br>X Others (please specify)<br>By nature of the global / fixed reimbursement, provider directly benefits from any efficiencies gained | No | |
| 11 | 2 | X DRG<br>X Per Diem<br>__ % of Charges<br>__ Bundled Services<br>__ Capitation or other budgeting<br>X Others (please specify) Case Rates | Yes | If yes - % of total payments for inpatient services in CY 2009 spent on quality incentive payments.<br>2.50% | __ admission reductions<br>__ day reductions<br>__ Others (please specify) | No | |

Additional Questions for Hospital Inpatient Services

1. List the five most common areas of quality and service incentives in your company's inpatient contracts:
    i. CMS Core Measures
    ii. HCAPHS
    iii. CPOE
    iv. Pharmacy Administration Process
    v. National Surgical Improvement Program

    Note: i & ii are part of our standard program as of 2009

2. Percent of total payments to RI Hospitals for inpatient services in CY 2009 spent on quality incentive payments. 1.3%

3. Percent of total payments to RI Hospitals for inpatient services in CY 2009 paid through units of service based on efficient resource use (i.e., DRG, Capitation, Bundled Service or partial/global budgeting):
    - Per diem 66%
    - DRG 10%
    - Case rates 20%
    - Global 4%
    - % of charge 0%

Part 2. Hospital Outpatient Services

- To be filled out for each general service (no specialty care, no rehab) institution with whom you contract in the state. Institution means hospital system if all contractual terms other than dollar amounts apply identically across all inpatient facilities in the contract.
- Outpatient Services include any services not involving an admission and covered under the contract with the institution.

| Institution/ System | Unit of Payment for Outpatient Services (check all that apply) | Are there Quality or Customer Service Incentives in Contract (y/n)[3]? | Utilization Incentives in Contract: (check all that apply) | Comments |
|---|---|---|---|---|
| 1 | __ Procedure-based methodology – using plan, provider or industry coding.<br>__ APC Code<br>X Other (please specify) Global Liability | If yes - % of total payments for outpatient services in CY 2009 spent on quality incentive payments. [4]<br>Gateway to global funding to ensure patient. quality | __ Visit/Volume Reduction<br>__ Others (please specify) | |
| 2 | X Procedure-based methodology – using plan, provider or industry coding. .<br>__ APC Code<br>__ Other (please specify) | If yes - % of total payments for outpatient services in CY 2009 spent on quality incentive payments.<br>3% | __ Visit/Volume Reduction<br>__ Others (please specify) | |

[3] Examples include supplemental payments beyond base fees for structural changes such as HIT, process measures or customer satisfaction.

[4] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

| Institution/ System | Unit of Payment for Outpatient Services (check all that apply) | Are there Quality or Customer Service Incentives in Contract (y/n)[3]? | Utilization Incentives in Contract: (check all that apply) | Comments |
|---|---|---|---|---|
| 3 | __ Procedure-based methodology – using plan, provider or industry coding.<br>__ APC Code<br>X Other (please specify) Global Liability | If yes - % of total payments for outpatient services in CY 2009 spent on quality incentive payments.<br>Gateway to global funding to ensure patient quality | __ Visit/Volume Reduction<br>__ Others (please specify) | |
| 4 | X Procedure-based methodology – using plan, provider or industry coding. .<br>__ APC Code<br>__ Other (please specify) | If yes - % of total payments for outpatient services in CY 2009 spent on quality incentive payments.<br>2.0% | __ Visit/Volume Reduction<br>__ Others (please specify) | |
| 5 | X Procedure-based methodology – using plan, provider or industry coding. .<br>__ APC Code<br>__ Other (please specify) | If yes - % of total payments for outpatient services in CY 2009 spent on quality incentive payments.<br>3.0% | __ Visit/Volume Reduction<br>__ Others (please specify) | |
| 6 | X Procedure-based methodology – using plan, provider or industry coding. .<br>__ APC Code<br>__ Other (please specify) | If yes - % of total payments for outpatient services in CY 2009 spent on quality incentive payments.<br>0.37% | __ Visit/Volume Reduction<br>__ Others (please specify) | |
| 7 | X Procedure-based methodology – using plan, provider or industry coding. .<br>__ APC Code<br>__ Other (please specify) | If yes - % of total payments for outpatient services in CY 2009 spent on quality incentive payments.<br>1.0% | __ Visit/Volume Reduction<br>__ Others (please specify) | |

| Institution/ System | Unit of Payment for Outpatient Services (check all that apply) | Are there Quality or Customer Service Incentives in Contract (y/n)[3]? | Utilization Incentives in Contract: (check all that apply) | Comments |
|---|---|---|---|---|
| 8 | X Procedure-based methodology – using plan, provider or industry coding. .<br>__ APC Code<br>__ Other (please specify) | If yes - % of total payments for outpatient services in CY 2009 spent on quality incentive payments.<br>0.37% | __ Visit/Volume Reduction<br>__ Others (please specify) | |
| 9 | X Procedure-based methodology – using plan, provider or industry coding. .<br>__ APC Code<br>__ Other (please specify) | If yes - % of total payments for outpatient services in CY 2009 spent on quality incentive payments.<br>2.5% | __ Visit/Volume Reduction<br>__ Others (please specify) | |
| 10 | X Procedure-based methodology – using plan, provider or industry coding. .<br>__ APC Code<br>__ Other (please specify) | If yes - % of total payments for outpatient services in CY 2009 spent on quality incentive payments.<br>0.37% | __ Visit/Volume Reduction<br>__ Others (please specify) | |
| 11 | X Procedure-based methodology – using plan, provider or industry coding. .<br>__ APC Code<br>__ Other (please specify) | If yes - % of total payments for outpatient services in CY 2009 spent on quality incentive payments.<br>0.50% | __ Visit/Volume Reduction<br>__ Others (please specify) | |

Additional Questions for Hospital Outpatient Services

1. List the five most common areas of quality and service incentives in your company's hospital outpatient contracts:

   See above – same as inpatient

2. Percent of total payments to RI Hospitals for outpatient services in CY 2009 spent on quality incentive payments:

   1.3%

3. Percent of total payments to RI Hospitals for inpatient services in CY 2009 paid through units of service based on efficient resource use (i.e., APC, Bundled Services or partial/global budgeting):

| | |
|---|---|
| Procedure-Based | 91% |
| Global Liability | 9% |

Part 3: Professional Groups

- "Professional Groups" is defined as non institutional/non facility groups with a valid contract and a single tax id number.
- Please provide for the top 10 groups (measured by $ paid in 2009).

| Group | Specialty Type | Unit of Payment for Services (check all that apply) | Are there Quality or Customer Service Incentives in Contract (y/n)[5]? | Utilization Incentives in Contract: (check all that apply) | Comments |
|---|---|---|---|---|---|
| 1 | PCP | X Procedure-based methodology – using CPT, plan, provider or other coding.<br>__ APC Code<br>__ Full/ Partial Capitation<br>__ Other (please specify) | If yes - % of payments in CY 2009 spent on quality incentive payments compared to total payments. [6]<br>Yes: ~12% | __ Visit/Volume Reduction<br>__ use of ancillary/referred services<br>__ use of diagnostic tests<br>__ over all efficiency of care<br>X use of pharmacy services<br>__ Others (please specify) | |
| 2 | Radiology | X Procedure-based methodology – using CPT, plan, provider or other coding.<br>__ APC Code<br>__ Full/ Partial Capitation<br>__ Other (please specify) | If yes - % of payments in CY 2009 spent on quality incentive payments compared to total payments.<br>None | __ Visit/Volume Reduction<br>__ use of ancillary/referred services<br>__ use of diagnostic tests<br>__ over all efficiency of care<br>__ use of pharmacy services<br>__ Others (please specify) | |

[5] Examples include supplemental payments beyond base fees for EMR adoption, structural changes, accreditation, process measures or patient satisfaction.

[6] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

| Group | Specialty Type | Unit of Payment for Services (check all that apply) | Are there Quality or Customer Service Incentives in Contract (y/n)[5]? | Utilization Incentives in Contract: (check all that apply) | Comments |
|---|---|---|---|---|---|
| 3 | Ortho | X Procedure-based methodology – using CPT, plan, provider or other coding.<br>__ APC Code<br>__ Full/ Partial Capitation<br>__ Other (please specify) | If yes - % of payments in CY 2009 spent on quality incentive payments compared to total payments.<br>None | __ Visit/Volume Reduction<br>__ use of ancillary/referred services<br>__ use of diagnostic tests<br>__ over all efficiency of care<br>__ use of pharmacy services<br>__ Others (please specify) | |
| 4 | PCP | X Procedure-based methodology – using CPT, plan, provider or other coding.<br>__ APC Code<br>__ Full/ Partial Capitation<br>__ Other (please specify) | If yes - % of payments in CY 2009 spent on quality incentive payments compared to total payments.<br>Yes: ~14% | __ Visit/Volume Reduction<br>__ use of ancillary/referred services<br>__ use of diagnostic tests<br>__ over all efficiency of care<br>__ use of pharmacy services<br>__ Others (please specify) | |
| 5 | Anes | X Procedure-based methodology – using CPT, plan, provider or other coding..<br>__ APC Code<br>__ Full/ Partial Capitation<br>__ Other (please specify) | If yes - % of payments in CY 2009 spent on quality incentive payments compared to total payments.<br>None | __ Visit/Volume Reduction<br>__ use of ancillary/referred services<br>__ use of diagnostic tests<br>__ over all efficiency of care<br>__ use of pharmacy services<br>__ Others (please specify) | |

| Group | Specialty Type | Unit of Payment for Services (check all that apply) | Are there Quality or Customer Service Incentives in Contract (y/n)[5]? | Utilization Incentives in Contract: (check all that apply) | Comments |
|---|---|---|---|---|---|
| 6 | Radiology | X Procedure-based methodology – using CPT, plan, provider or other coding. .<br>__ APC Code<br>__ Full/ Partial Capitation<br>__ Other (please specify) | If yes - % of payments in CY 2009 spent on quality incentive payments compared to total payments.<br>None | __ Visit/Volume Reduction<br>__ use of ancillary/referred services<br>__ use of diagnostic tests<br>__ over all efficiency of care<br>__ use of pharmacy services<br>__ Others (please specify) | |
| 7 | Surgery | X Procedure-based methodology – using CPT, plan, provider or other coding.<br>__ APC Code<br>__ Full/ Partial Capitation<br>__ Other (please specify) | If yes - % of payments in CY 2009 spent on quality incentive payments compared to total payments.<br>None | __ Visit/Volume Reduction<br>__ use of ancillary/referred services<br>__ use of diagnostic tests<br>__ over all efficiency of care<br>__ use of pharmacy services<br>__ Others (please specify) | |
| 8 | Radiology | X Procedure-based methodology – using CPT, plan, provider or other coding.<br>__ APC Code<br>__ Full/ Partial Capitation<br>__ Other (please specify) | If yes - % of payments in CY 2009 spent on quality incentive payments compared to total payments.<br>None | __ Visit/Volume Reduction<br>__ use of ancillary/referred services<br>__ use of diagnostic tests<br>__ over all efficiency of care<br>__ use of pharmacy services<br>__ Others (please specify) | |

| Group | Specialty Type | Unit of Payment for Services (check all that apply) | Are there Quality or Customer Service Incentives in Contract (y/n)[5]? | Utilization Incentives in Contract: (check all that apply) | Comments |
|---|---|---|---|---|---|
| 9 | Emergency Medicine | X Procedure-based methodology – using CPT, plan, provider or other coding.<br>__ APC Code<br>__ Full/ Partial Capitation<br>__ Other (please specify) | If yes - % of payments in CY 2009 spent on quality incentive payments compared to total payments.<br>Yes – 1% | __ Visit/Volume Reduction<br>__ use of ancillary/referred services<br>__ use of diagnostic tests<br>X over all efficiency of care<br>__ use of pharmacy services<br>__ Others (please specify) | |
| 10 | PCP | X Procedure-based methodology – using CPT, plan, provider or other coding.<br>__ APC Code<br>__ Full/ Partial Capitation<br>__ Other (please specify) | If yes - % of payments in CY 2009 spent on quality incentive payments compared to total payments.<br>Yes: 6% | __ Visit/Volume Reduction<br>__ use of ancillary/referred services<br>__ use of diagnostic tests<br>__ over all efficiency of care<br>__ use of pharmacy services<br>__ Others (please specify) | |

Additional Questions for Professional Groups

1. List the five most common areas of quality and service incentives in your company's professional group contracts:
    i. Electronic Medical Records
    ii. Hedis
    iii. NCQA Certification
    iv. Management of Complex Members
    v. Generic Prescribing

2. Percent of total payments to these ten professional groups in CY 2009 spent on quality incentive payments. 5.0%

3. Percent of total payments to these ten professional groups in CY 2009 paid through units of service based on efficient resource use (i.e., APC, Bundled Services or partial/global budgeting): <1.0%

**Blue Cross & Blue Shield of Rhode Island**

To: Health Plan Contacts for Rate Factor Filings
From: John Cogan, Office of the Health Insurance Commissioner
Date: April 23, 2010

Re: Resources for Health System Improvements - Survey

OHIC Regulation Two lists standards to be used by the Health Insurance Commissioner for the assessment of the conduct of Health Plans for their efforts aimed at Improving the Efficiency and Quality of Health Care Delivery and Increasing Access to Health Care Services. The standards include the following plan activities:

1. Directing resources, including financial contributions, toward system-wide improvements in the state's health care system related to quality, access and efficiency, including providing support to local collaboratives, organizations and initiatives that promote quality, access and efficiency.

2. Participating in the development and implementation of public policy issues related to health.

To assist the Commissioner in this assessment, as part the rate factor filing process, please itemize and quantify your organization's contributions of finances and other material assets to these efforts in Rhode Island in calendar year 2009 in the following table[1].

| **System-wide improvement activity** | **Brief description of activity** | **Value of 2009 Plan contributions** |
|---|---|---|
| Primary Care Infrastructure Support | BCBSRI provides:<br>• Financial support for infrastructure associated with progressing multiple large primary care groups toward the patient centered medical home practice design and quality improvement activities | ~$4.8m |

[1] The contributions can be to an entity other than a provider to improve medical and prevention services for all Rhode Islanders and to promote a coherent, integrated and efficient statewide healthcare system.

| System-wide improvement activity | Brief description of activity | Value of 2009 Plan contributions |
|---|---|---|
| CSI-RI | BCBSRI provides:<br>• Financial support for nurse care manager, project management, and care management PMPM<br>• In-kind support through participation in CSI Steering committee and Co-chair of Training and Support committee | ~$800,000 |
| current*care* Health Information Exchange (HIE) | BCBSRI provides:<br>• Financial support<br>• Support of the development of the HIE strategic and operational plans.<br>• Support the establishment of an HIT Regional Extension Center. | $570,000 |
| EHR Grant Program | BCBSRI provides:<br>• Financial support for both new and existing users of EHR technology.<br>• $2,500 per practice funding for an EHR pre-implementation readiness assessment to prepare for successful implementation.<br>• $5,000 per physician support to pay for the purchase of a certified EHR. | $519,500 |

| System-wide improvement activity | Brief description of activity | Value of 2009 Plan contributions |
|---|---|---|
| Rhode Island Primary Care Educational Loan Repayment Program | BCBSRI provides:<br>• Financial support<br>• Participation in development of selection criteria and selection of applicants | $500,000 (December 2008) |
| Quality Counts | BCBSRI provides:<br>• Financial support for EHR adoption and quality metric reporting and results | $448,000 |
| BCBSRI Wellness Van | BCBSRI provides:<br>• Free health screenings and prevention information to approximately 9,000 Rhode Islanders, including more than 900 uninsured. | $317,000 |
| Rhode Island Quality Institute (RIQI) | BCBSRI provides:<br>• Financial support<br>• Staff Technical Assistance—working and steering committees<br>• Jim Purcell, President & CEO of BCBSRI is the Chair of the Board of Directors and serves on several committees including the RIQI Operations Committee. | $300,000 |
| ICU Collaborative | BCBSRI provides:<br>• Financial and professional support | $162,000 |

| **System-wide improvement activity** | **Brief description of activity** | **Value of 2009 Plan contributions** |
|---|---|---|
| Co-location of behavioral health and primary care | BCBSRI provides:<br>• Financial support for the integration of behavioral health into primary care practices across the state | ~$200,000 |
| Rhode Island Free Clinic | BCBSRI provides:<br>• Volunteer Support—Dr. Gus Manocchia<br>• Financial support for operations<br>• Financial incentives to recruit new volunteers and expand physician volunteer network<br>• BCBSRI Community Wellness Van offers free screenings every monthly "Lottery" night. | $50,000 |
| HealthRIte | BCBSRI provides:<br>• Financial support | $30,000 |
| Gateway Mental Health First Aid | BCBSRI provides:<br>• Financial support.<br>• Professional assistance | $20,000 |

| System-wide improvement activity | Brief description of activity | Value of 2009 Plan contributions |
|---|---|---|
| Rhode Island Kids Count – Covering Kids RI | BCBSRI provides:<br>• Linda Newton is member of Advisory Council<br>• BCBSRI is Coalition Member<br>• Participated in the Leadership Roundtables for Children with Special Health Care Needs and the DHS RIte Care Consumer Advisory Committee<br>• Development of an Issue Brief on Preterm Births | $20,000 |
| Amos House Rite Care Access Program | BCBSRI provides:<br>• Payment for over 2000 birth certificates required for health care benefit applications and recertification. | $10,000 |
| RIMS Physician Health Program | BCBSRI provides:<br>• Financial support | $10,000 |
| March of Dimes | BCBSRI provides:<br>• Financial support to this annual forum.<br>• Senior level manager on the Board of Directors | $8500 |

| **System-wide improvement activity** | **Brief description of activity** | **Value of 2009 Plan contributions** |
|---|---|---|
| Women's Cancer Screening Program with the RI DOH | BCBSRI provides:<br>• In-kind design, printing and delivery of all advertising and signage for the twice a year, hospital based screening events. | In kind value:<br>$2,304 |
| Rhode Island Healthy Schools Coalition | BCBSRI provides:<br>• Staff support<br>• Financial support of annual breakfast<br>• Participation on Nutrition Guideline Subcommittee which is responsible for developing the nutrition guidelines for RI schools. | $500 |
| RI Breastfeeding Coalition | BCBSRI provides:<br>• Staff support at 12 meetings per year.<br>• Sr. level manager on board of directors.<br>• BCBSRI is a breastfeeding friendly workplace. Acknowledged by RIBC as a Silver level employer. | In kind |
| Rhode Island Task Force on Prematurity | BCBSRI provides:<br>• Committee representation | In kind |
| Healthy Eating Active Living Collaborative | BCBSRI provides:<br>• Staff support at 1-2 meetings per month. | In kind |

| **System-wide improvement activity** | **Brief description of activity** | **Value of 2009 Plan contributions** |
|---|---|---|
| Rhode Island Heart Disease and Stroke Prevention Worksite, Community and Prevention Workgroup | BCBSRI provides:<br>• Staff support at 1 meeting per month. | In kind |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *BCBS-126629620* | *State:* | *Rhode Island* |
| *Filing Company:* | *Blue Cross & Blue Shield of Rhode Island* | *State Tracking Number:* | |
| *Company Tracking Number:* | *GM-201005* | | |
| *TOI:* | *H15G Group Health - Hospital/Surgical/Medical Expense* | *Sub-TOI:* | *H15G.001 Any Size Group* |
| *Product Name:* | *Group Commercial Medical* | | |
| *Project Name/Number:* | *Group Commercial Rating Factors for 2011/GM-201005* | | |

# Supporting Document Schedules

**Item Status:** **Status Date:**

**Bypassed - Item:** Actuarial Certification - Life & A&H
**Bypass Reason:** Not required
**Comments:**

**Item Status:** **Status Date:**

**Bypassed - Item:** Actuarial Memorandum - A&H Rate Revision Filing
**Bypass Reason:** Not required
**Comments:**

**Item Status:** **Status Date:**

**Bypassed - Item:** A&H Experience
**Bypass Reason:** Not required
**Comments:**

**Item Status:** **Status Date:**

**Bypassed - Item:** Exhibits - A&H
**Bypass Reason:** Not required
**Comments:**

**Item Status:** **Status Date:**

**Bypassed - Item:** Premium Rate Sheets - Life & A&H
**Bypass Reason:** Not required
**Comments:**

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *BCBS-126629620* | *State:* | *Rhode Island* |
| *Filing Company:* | *Blue Cross & Blue Shield of Rhode Island* | *State Tracking Number:* | |
| *Company Tracking Number:* | *GM-201005* | | |
| *TOI:* | *H15G Group Health - Hospital/Surgical/Medical Expense* | *Sub-TOI:* | *H15G.001 Any Size Group* |
| *Product Name:* | *Group Commercial Medical* | | |
| *Project Name/Number:* | *Group Commercial Rating Factors for 2011/GM-201005* | | |

**Item Status:** **Status Date:**

**Bypassed - Item:** Health Insurance Checklist

**Bypass Reason:** Not required

**Comments:**